

## **EXHIBIT A**



Service Office:  
200 BLOOR STREET EAST  
TORONTO, ONTARIO  
CANADA M4W 1E5

Policy No. (For Internal Use Only)

### Application for Life Insurance

- ☐ John Hancock Life Insurance Company (U.S.A.)  
☐ John Hancock Variable Life Insurance Company  
☐ John Hancock Life Insurance Company  
(hereinafter referred to as The Company)

• Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s) and/or Owner(s).

#### Proposed Life Insured (Life One)

1. a) Name First Sara Middle Hollander Last Hollander  
b) Date of Birth mm dd yy 6 6 1930 c) Sex ☐ M ☐ F  
d) Place of Birth State Romania Country \_\_\_\_\_  
e) Citizenship ☒ U.S. ☐ Other \_\_\_\_\_  
f) Social Security/Tax ID Number 0171278123412  
g) Driver's License No. She does not drive State N/A  
h) Home Address Street No. & Name, Apt No. 135 Keap Street  
City Franklin State NY Zip code 11211  
i) Years at this Address 40  
j) Tel Nos. Home ( ) Business ( )  
k) Name of Employer \_\_\_\_\_  
Address of Employer Street No. & Name, Apt No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
l) Occupation Retired

#### Proposed Life Insured (Life Two)

2. a) Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
b) Date of Birth mm dd yy \_\_\_\_\_ c) Sex ☐ M ☐ F  
d) Place of Birth State \_\_\_\_\_ Country \_\_\_\_\_  
e) Citizenship ☐ U.S. ☐ Other \_\_\_\_\_  
f) Social Security/Tax ID Number \_\_\_\_\_  
g) Driver's License No. \_\_\_\_\_ State \_\_\_\_\_  
h) Home Address Street No. & Name, Apt No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
i) Years at this Address \_\_\_\_\_  
j) Tel Nos. Home ( ) Business ( )  
k) Name of Employer \_\_\_\_\_  
Address of Employer Street No. & Name, Apt No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
l) Occupation \_\_\_\_\_

#### Owner - Complete information only if Owner is other than Proposed Life Insured.

If Trust Owner, complete questions 3. a), d) and e) and Trust Certification PSS101.

Date of Trust mm dd yy 2 11 2008

3. a) Name The Sara Hollander Irrevocable Trust  
b) Date of Birth mm dd yy \_\_\_\_\_ c) Relationship to Proposed Life Insured(s) \_\_\_\_\_ d) Social Security/Tax ID Number 266231472  
e) Address Street No. & Name, Apt No. 8 Oak Street, Chf/ten City NJ State 07014 Zip code \_\_\_\_\_

4. Multiple Owners - Provide details as above for other owner(s) on a separate page.

Type of ownership ☐ Joint with right of survivorship ☐ Tenants in Common

**Other information - MUST BE COMPLETED**

5. Is there, or will there be, an understanding or agreement providing for a party, other than the Owner designated in question 3. a), to obtain any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application?  
☒ No ☐ Yes - give details
6. a) What is the source of the funding for the policy(ies) currently applied for? Income & Savings  
 b) Will the Owner, now or in the future, be paying premiums funded by an individual and/or an entity other than the Proposed Life Insured(s), or the Proposed Life Insured's employer? ☐ Yes - If Yes, answer question 7. ☒ No - If No, proceed to question 8.
7. Will the premiums be financed through a loan?  
☐ No - If No, describe the funding arrangement.  
☐ Yes - If Yes, answer the following questions.
- a) What is the interest rate per annum? \_\_\_\_\_ %  
 b) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid on maturity?  
☐ No ☐ Yes - give details  
 c) What is the duration of the loan?  
 d) Who is the lender?  
 e) What amount and type of collateral is required to secure the loan?
- Amount \$ \_\_\_\_\_ Type of Collateral \_\_\_\_\_

**Beneficiary Information - Subject to change by Owner**

8. a) Name of Primary Beneficiary First Given Initial Last  
Sarah Hollander Irrevocable Trust  
 b) Relationship to Proposed Life Insured(s)  
 c) Name of Secondary Beneficiary First Given Initial Last  
 d) Relationship to Proposed Life Insured(s)

**Coverage Applied For**

9. Complete the applicable Policy Details Form NB5007 (Universal Life), NB5008 (Variable Life) or NB5013 (Term & Traditional Life) for details of the policy being applied for, including Supplementary Benefits and other benefit options.

**Juvenile Insurance - Do not complete for Children's Insurance Rider.**

10. a) Are all siblings equally insured? ☐ Yes ☒ No  
 b) Amount of life insurance currently in force or pending on parent(s)/guardian(s) \$ \_\_\_\_\_  
 If none, give details.

**Existing and Pending Insurance - Proposed Life Insured(s)**

11. a) Total insurance in force on the Proposed Life Insured(s), including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.  
 b) Including this application, total insurance currently pending with all companies.  
 c) Of the above pending amount in 11. b), how much do you intend to accept?  
 d) Have you ever had an application for life or health insurance declined, postponed, rated or offered with a reduced face amount?  
 Life One: ☒ No ☐ Yes - give details  
 Life Two: ☐ No ☐ Yes - give details

- e) Provide information for each policy in force on the Proposed Life Insured(s), including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. (Attach additional page if necessary.)

Proposed Life Insured	Company	Insurance				Issue Date		To Remain in Force?		Face Amount
		Group	Personal	Business	Term	dd	mm/yyyy	Yes	No	
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

**Existing and Pending Insurance - Proposed Life Insured(s) (continued)**

11. f) Is Disability Insurance (DI) with Provident or Long Term Care (LTC) Insurance with the Company currently being applied for?  
If Yes, provide ☐ DI date of application

☐ LTC date of application

Life One				Life Two			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No			
mm	dd	yyyy		mm	dd	yyyy	
mm	dd	yyyy		mm	dd	yyyy	

**Existing Insurance - Owner(s) Replacement(s) - MUST BE COMPLETED**

12. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)? ☐ Yes ☒ No If Yes, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011.

**Financial Questions**

Complete when applying for Face Amount of \$250,000 or more, or any amount of Business Insurance, or when a Proposed Life Insured is over age 70. (Please submit copies of financial statements, estate analysis, contractual agreements, etc.)

13. a) What is the purpose of this insurance?  
(e.g. estate conservation, buy-sell, keyperson)

- b) How was the need for the Face Amount determined?

*Estate Planning  
Based on assets*

- c) Gross annual earned income (salary, commissions, bonuses, etc.)

- d) Gross annual unearned income (dividends, interest, net real estate income, etc.)

- e) Household net worth (combined)

- f) In the last 5 years, has/have either of the Proposed Life Insured(s), or the business had any major financial problems (bankruptcy, etc.)? ☒ No ☐ Yes - give details

Life One	Life Two
\$ 0	\$
\$ 1,000,000	\$
\$ 1,000,000	\$

**Business Insurance - Complete for ALL Business Insurance**

	Current Year	Previous Year
14. a) Assets	\$	\$
b) Liabilities	\$	\$
c) Gross Sales	\$	\$
d) Net Income after taxes	\$	\$
e) Fair Market Value of the business	\$	\$

- f) What percentage of the business is owned by the Proposed Life Insured(s)? %

- g) Are other partners/owners/executives being insured? ☐ Yes ☐ No  
If Yes, give details.

**Smoking Questions**

15. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?

Proposed Life Insured (Life One) ☒ No ☐ Yes - give details below

Product	Frequency	Current	Past	Date last used
Cigarettes	pack(s) / day	<input type="checkbox"/>	<input type="checkbox"/>	mm dd yy
Cigars	x / day	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	x / day	<input type="checkbox"/>	<input type="checkbox"/>	

Proposed Life Insured (Life Two) ☐ No ☐ Yes - give details below

Product	Frequency	Current	Past	Date last used
Cigarettes	pack(s) / day	<input type="checkbox"/>	<input type="checkbox"/>	mm dd yy
Cigars	x / day	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	x / day	<input type="checkbox"/>	<input type="checkbox"/>	

**Lifestyle Questions - Please provide details in No. 21 for Yes answers. (Page 4)**

16. Do you engage in regular exercise?

Proposed Life Insured (Life One) ☐ No ☐ Yes - give details below

- a) What type of exercise?

- b) How many times a week?

- c) How long? (Hours or minutes per occasion)

Proposed Life Insured (Life Two) ☐ No ☐ Yes - give details below

- a) What type of exercise?

- b) How many times a week?

- c) How long? (Hours or minutes per occasion)

17. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?

18. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years? If Yes, please complete Aviation Questionnaire NB5009.

- b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years? If Yes, please complete Aviation Questionnaire NB5010.

Life One	Life Two
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Lifestyle Questions (continued) - Please provide details in No. 21 for Yes answers.**

19. a) Have you committed 2 or more moving violations within the last 2 years?  
 b) Have you been convicted of driving while intoxicated or while otherwise impaired?
20. In the last 10 years, have you been convicted of a criminal offense?

Life One		Life Two	
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**21. Proposed Life Insured (Life One)**

Question No. \_\_\_\_\_  
 Details for any "Yes" answers to Lifestyle Questions

**Proposed Life Insured (Life Two)**

Question No. \_\_\_\_\_  
 Details for any "Yes" answers to Lifestyle Questions

**Doctor/Physician - MUST BE COMPLETED****Proposed Life Insured (Life One)**

22. a) Date of last visit 11 8 09  
 b) Reason for the visit check-up  
 c) Diagnosis or outcome of the visit  
 d) Treatment/medication prescribed  
 e) Name of doctor/physician consulted

First Middle Last  
Dr. George Moskowitz

f) Address Street No. & Name, Suite No.  
1318 42nd Street  
 City State Zip code  
Brooklyn NY 11219

- g) Provide name and address of doctor/physician with your complete medical records if other than above.

Name First Middle Last

Address Street No. & Name, Suite No.

City State Zip code

**Proposed Life Insured (Life Two)**

- a) Date of last visit 11 8 09  
 b) Reason for the visit  
 c) Diagnosis or outcome of the visit  
 d) Treatment/medication prescribed  
 e) Name of doctor/physician consulted

First Middle Last

f) Address Street No. & Name, Suite No.  
 City State Zip code

- g) Provide name and address of doctor/physician with your complete medical records if other than above.

Name First Middle Last

Address Street No. & Name, Suite No.

City State Zip code

**Medical Certification - Complete this section when submitting Medical Examination of another Insurer.**

23. The attached examination is on the life of:

Name of Proposed Life Insured	Name of Insurance Company	Date of Examination
1.		month day year
2.		

- a) To the best of your knowledge and belief, are the statements in the examination true as of the date this application is signed?  
 b) Has the person who was examined, consulted a doctor/physician or received medical or surgical advice since the date of the examination? If Yes, give details:

Life One		Life Two	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Special Requests**

24.



## Declarations and Authorizations

## DECLARATIONS

The Proposed Life Insured(s) and Owner(s) (Parent or Guardian) declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of my/our knowledge and belief.

In addition, I/we understand and agree that:

1. The statements and answers in this application, which include the Policy Details and any supplemental form relating to the health, avocation or lifestyle of the Proposed Life Insured(s), will become part of the insurance policy issued as a result of this application.
2. (a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered. The insurance will not be in effect if there has been a deterioration in the insurability of any proposed life insured(s) since the date of the application.

If the Temporary Insurance Agreement (TIA) coverage is in effect and a subsequent policy is issued within 90 days of the date of the original application, the above paragraph only applies to any amount in excess of the TIA amount.

2. (b) If premiums are paid prior to delivery of the policy and the terms and conditions of the Temporary Insurance Agreement are satisfied, insurance prior to the effective date shall be provided only under the Agreement and according to its terms.
3. ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

## AUTHORIZATION TO OBTAIN INFORMATION

I/We, the Proposed Life Insured(s), authorize:

1. John Hancock Life Insurance Company (U.S.A.), John Hancock Variable Life Insurance Company or John Hancock Life Insurance Company (The Company) to obtain an investigative consumer report on me/us.
  2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me/us or any minor child/children who is/are to be insured.
- The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. In turn, The Company is free to disclose such information and any information developed during its evaluation of my/our application to:
- (a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me/us; (d) me/us; (e) any medical professional designated by me/us; or (f) any person or entity entitled to receive such information by law or as I/we may further consent.

I/We acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc. This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original. Information collected under this authorization will be used by The Company to evaluate my/our application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am/We are entitled, or my/our authorized representative is entitled, to a copy of this authorization.

## OWNER/TAXPAYER CERTIFICATION - MUST BE COMPLETED

Under the penalties of perjury, I the Owner, certify that:

1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), AND
2. Check the applicable box:  
☒ I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or  
 (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, AND  
☐ The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, AND
3. I am a U.S. resident (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Signatures - Please read all of the above Declarations and Authorizations before signing this form.

Signed at City		State		Date		Day of		Year	
Clifton		NJ		12/12		February		2008	
Signature of Agent/Regulated Representative (as Witness)									
<input checked="" type="checkbox"/> I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, <u>AND</u> <input type="checkbox"/> The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, <u>AND</u>									
<input checked="" type="checkbox"/> I am a U.S. resident (including a U.S. resident alien). The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.									
<input checked="" type="checkbox"/> Consent by Juvenile Insured(s) of Parent or Guardian, Father or Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian									
Signed at City		State		Date		Day of		Year	
Clifton		NJ		12/12		February		2008	
Signature of Agent/Regulated Representative (as Witness)									
<input checked="" type="checkbox"/> I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, <u>AND</u> <input type="checkbox"/> The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, <u>AND</u>									
<input checked="" type="checkbox"/> I am a U.S. resident (including a U.S. resident alien). The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.									
<input checked="" type="checkbox"/> Consent by Juvenile Insured(s) of Parent or Guardian, Father or Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian									
Signed at City		State		Date		Day of		Year	
Clifton		NJ		12/12		February		2008	
Signature of Agent/Regulated Representative (as Witness)									
<input checked="" type="checkbox"/> I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, <u>AND</u> <input type="checkbox"/> The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, <u>AND</u>									
<input checked="" type="checkbox"/> I am a U.S. resident (including a U.S. resident alien). The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.									
<input checked="" type="checkbox"/> Consent by Juvenile Insured(s) of Parent or Guardian, Father or Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian									